Response to Notice of Rulemaking for Rule 865 – Standards for Fertility Coverage

Community Health Options appreciates the opportunity to provide written comments and questions regarding proposed Rule 865 – Standards for Fertility Coverage. Community Health Options would like further clarification on the services covered after review 24-A M.R.S. § 4320-U and Chapter 865.

Costs associated with Surrogacy or Gestational Carrier

Section 6. Permissible Benefit Limitations and Exclusions, 3.B. states "*Medical services rendered to a surrogate for the purposes of childbearing where the surrogate is not covered by the carrier's policy or contract"*

Community Health Options is requesting clarity concerning when or if costs for the pregnancy from fertility treatment for a non-Member surrogate or gestational carrier are required to be covered.

Definitions

Community Health Options noted that there is not a definition regarding the use of the "lifetime" utilized throughout the proposed rule, is lifetime in reference to the that of the policy or the Member?

Cycles of IVF

Within Section 6.2 it states "*Benefits for any combination of in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or fresh or frozen embryo transfer (FET) may be limited to two lifetime cycles*" but within Section 6.3.F states "*In vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer for persons who have not used all reasonable less expensive and medically appropriate treatments for infertility, or who have exceeded the limit of four covered completed egg retrievals*."

Community Health Options would like to understand what the benefit limitation is for the number of IVF cycles?

Prescription Drug Coverage

Section 5.9 "*Medications, including injectable infertility medications, even if the contract or policy does not provide prescription drug benefits. Where a contract or policy provides both prescription drug and medical and hospital benefits, infertility drugs shall be covered under the prescription drug coverage;"*

Does this mean that a provider can't buy and bill under the medical benefit, and means the provider must obtain the medication from a pharmacy that is contracted with the carrier, or the Member obtains the medication and self-injects or brings the medication to the practice?

Within Section 4.3 it does not specifically call out the use of UM tools for the prescription benefit. Can Community Health Options implement utilization management strategies for the prescription benefit? Examples: step therapy, prior authorization, quantity limits (e.g., 30-day supply) or drug exclusions (requiring the use of a formulary product)?